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Editorials

Women's Health, Women's Lives, Women's Rights

> "A male-dominated society is a threat to public health."
> —*Jonathan Mann*[1]

With this issue we turn again to the theme of women's health. A wealth of manuscripts attests to a long overdue but rising interest in women's health as a public health concern on the part of those who conduct research and make policy. Thus, the Women's Congressional Caucus, in response to pressure from the women's health movement, public health leaders, and other advocates initiated a women's health research agenda. The agenda should provide impetus for public health research policies and programs that address women's needs. It does not alone ensure the enhanced and continued involvement of women in shaping policies and programs.

Without denying that access to health care, reproductive choices, and screening procedures or that dietary factors, exercise, and related behaviors are necessary to maintain health, we need to acknowledge the predominance of socioeconomic and cultural determinants. Women live in households, communities, and cities, and in times, places, and circumstances that spell health or disease, life or death, with greater certainty than does access to health care.

As an example, assaults by husbands, exhusbands, and lovers cause more injuries to women than motor vehicle accidents, rape, and muggings combined.[2] Health officials estimate that each year more than 4 million women are battered and more than 4 thousand are killed by such "intimate assaults."[3] Yet public health initiatives for preventing violence against women and helping women and children entrapped by violence are sadly lacking.

At the same time, millions of women suffer a daily toll of violence in their communities from drugs, gangs, pervasive unemployment, homelessness, or the police.

Many advocates for women and public health workers maintain that complex environmental factors are the preeminent determinants of women's health. In practice, to establish that such complex factors are causes of given states of health is difficult if not entirely impossible. Nor will such intractable problems as poverty and violence yield to simple or short-term interventions.

Two groups of researchers whose articles appear in this issue have grappled with the methodological difficulties of probing the effect of the environment and have opened up new perspectives.

Winkvist and colleagues, in their article, "A New Definition of the Maternal Depletion Syndrome," provide a new conceptual framework. They show that some poor maternal and infant health outcomes in developing countries are not the result of the nutritional stresses of successive and closely spaced pregnancies and lactations, but of insufficient food. Prevention requires not just family planning services for women but the provision of adequate nutrition for girls from birth through child-bearing age. This requires changes in the social environment.

Zapata and colleagues used an innovative study design in their article, "The Influence of Social and Political Violence on the Risk of Pregnancy Complications." Their approach was to identify communities in Chile that differed in the degree of

Editor's Note. See related articles by Winkvist et al. on p 691 and by Zapata et al. on p 685 of this issue.

military and police repression and to compare the number of complications experienced by healthy pregnant women. The excellent qualities of Chilean health care, as well as the characteristics of the communities, are perhaps too distinctive to permit replication of the study in the United States. Still, this work points out that we must adopt community-wide approaches when attempting to understand determinants of women's health. This is particularly relevant for women in minority communities and communities of low income.

Perhaps public health workers are now beginning to understand two delimiting concepts that the women's movement has long espoused, namely, centrality and totality. The term "centrality," as used in this context, defines health problems as women themselves experience those problems. Centrality casts women as active decision makers in their own lives. This is to reject and reshape the all too common view of women as passive recipients of health care and public health action. Rape, abortion, abuse by husbands or lovers, sense of powerlessness, oppression in terms of gender, race, culture, and economics are all frequent experiences for women. Health interventions from a public health perspective that involve women must address these issues as defined by women. The term "totality," as used here, defines the health problems of women as deeply implanted in the statuses that derive from their multiple social relations. Thus totality sees women as inextricably involved with their families and communities. Women cannot separate their roles as workers, caretakers, mothers, sisters, and wives.

It is time for women to join fully in determining policies that affect them. As public health workers participate in forging a women's health agenda, we may do well to recognize the women's health movement and its contributions. This movement has long striven to have women gain their proper place in determining the policies and programs that affect them. It has given a clear answer to those who ask what women really want. The answer is equal rights and power over our own lives and our common destiny. □

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Women and Children First: Towards a US Family Policy

This issue of the *American Journal of Public Health* on women's health appears at a critical moment. This is a time of intense debate on restructuring the US health care system; a time of increased popular involvement in the political process; and a time of economic hardship for millions of Americans and thus a time when we should rethink our social and economic priorities. As public health workers know all too well, the social, economic, and political context in which people live and work strongly influences the health both of individuals and of populations. It might, therefore, be useful to consider the issue of women's health within the framework of the socioeconomic status of women in the early 1990s. Since a full analysis of this topic is impossible in this brief editorial, I will focus on some of the key issues in the lives of economically disadvantaged women in the United States.

During the last quarter century, women in the United States have moved in significant numbers into a wide variety of professional, managerial, and entrepreneurial occupations; yet a dual labor market continues to exist, and the majority of women continue to work in low-pay, low-status jobs doing primarily clerical, service, and sales work. Moreover, although women's wages, particularly those of young women, have risen in recent years, full-time, year-round female workers earn only about 70% of the earnings of comparable male workers. This gap is a central factor that keeps a vast number of women—and their children—in poverty.

In 1990, 13.5% of the US population—33.6 million people—were officially classified as poor, that is, as living below even the unrealistically low federal poverty line.[1] The composition of poor families has changed significantly over the past 30 years. In 1959, 23% of all poor families were headed by women; by 1989 that figure had risen to 51.7%. Today nearly 40% of the US poor are children and more than half are members of female-headed families.[2]

Moreover, the situation of families headed by African-American and Latina women is even more bleak. They continue to be at greatest risk of poverty. Among poor Black families in 1989, nearly three-quarters, 73.4%, were headed by women with no husband present; among poor families of Latino origin, nearly half, 46.8%, were headed by women.[3]

Since the mid-1980s several critical, often life-threatening problems that particularly afflict women and children have added to the extraordinary toll that poverty takes on their health and well-being: The crack epidemic with its alarming number of "crack babies" and the subsequent prosecution of poor, usually African-American women for the "prenatal crime" of delivering drugs to the fetus; the dramatic escalation of violence on the streets of our cities with people of color all too often the victims; the ubiquity of homelessness with a significant percentage of homeless families headed by women; and the continuing existence of hunger, particularly among female-headed families.

But perhaps the most disturbing phenomenon of the early 1990s is the denigration of the poor and the blatant perpetuation of sexist and racist stereotypes. To equate people living in poverty, particularly recipients of Aid to Families with Dependent Children (AFDC), with the "underclass" is to brand them unfit, unmotivated, unwilling, or unable to do their part to achieve their piece of the American dream. In reality, such an "underclass" constitutes but a small segment of the poor. Popular perception fueled by demagogic leaders also erroneously labels the majority of the poor as people of color; thus, the disparaging of "welfare mothers" becomes coded language for racism.

Consequently, in these difficult eco-